Highlights

Health Status and Determinants

Population characteristics

Important changes in the U.S. population will shape future efforts to improve health and health care. Two major changes in the demographic characteristics of the U.S. population are the growth of the elderly population and the increasing racial and ethnic diversity of the Nation.

From 1950 to 2000 the proportion of the population that is **elderly** rose from 8 to 12 percent. By 2050 it is projected that one in five Americans will be 65 years of age or over (figure 2).

The **racial and ethnic composition** of the Nation has changed over time. The Hispanic population and the Asian and Pacific Islander population have grown more rapidly than other racial and ethnic groups in recent decades. In 2000 more than 12 percent of the U.S. population identified themselves as Hispanic and almost 4 percent as Asian or Pacific Islander (figure 3).

In 2000 the percent of Americans living in **poverty** dropped to 11.3 percent overall. However, the poverty rate differs significantly among population subgroups. More than one-quarter of black and Hispanic children lived in poor families in 2000 (figure 4 and table 2).

Fertility

Birth rates for teens have continued to decline, while birth rates for women 20–44 years of age increased in 2000. The overall fertility rate increased for the third year in 2000 after dropping each year during 1990–97.

The **birth rate for teenagers** declined for the ninth consecutive year in 2000, to 48.5 births per 1,000 women aged 15–19 years, an all-time low for the Nation. Between 1991 and 2000 the teen birth rate declined more for 15–17 year olds than for 18–19 year olds (by 29 percent compared with 16 percent) (table 3).

The **birth rate for unmarried women** increased 2 percent in 2000 to 45.2 births per 1,000 unmarried women ages 15–44 years, but was still 4 percent below its high in 1994. The birth rate for unmarried black women increased slightly in 2000 to 72.5 per 1,000, after having declined steadily over the past decade, and the birth rate for unmarried Hispanic women increased for the second year to 97.3 per 1,000 (table 9).

Health Behaviors and Risk Factors

Health behaviors and risk factors have a significant effect on health outcomes. Cigarette smoking increases the risk of lung cancer, heart disease, emphysema, and other respiratory diseases. Overweight and obesity increase the risk of death and disease as well as the severity of disease. Regular physical activity reduces mortality, lessens the risk of disease, and enhances physical functioning. Heavy and chronic use of alcohol and use of illicit drugs increase the risk of disease and injuries. Environmental exposures also affect health. For example, poor air quality contributes to respiratory illness, cardiovascular disease, and cancer.

Since 1990 the percent of **adults who smoke** cigarettes has declined only slightly. In 2000, 26 percent of men and 21 percent of women were smokers. Cigarette smoking by adults is strongly associated with educational attainment. Adults with less than a high school education were almost three times as likely to smoke as those with a bachelor's degree or more education in 2000 (figure 7 and tables 61 and 62).

The percent of **high school students who smoke** cigarettes increased in the early 1990s. Since 1997 the percent of students who smoke has declined. In 2001, 29 percent of high school students reported smoking during the past month (figure 7).

Cigarette smoking during pregnancy is a risk factor for poor birth outcomes such as low birthweight and infant death. In 2000 the proportion of mothers who smoked cigarettes during pregnancy declined to 12 percent, down from 20 percent in 1989. Smoking rates for mothers ages 18–19 years decreased in 2000, after increasing each year since 1995. Mothers in this age group remained more likely to smoke during pregnancy than mothers at other ages (figure 7 and table 11).

The prevalence of **overweight and obesity** among adults has increased substantially since 1976–80. In 1999 an estimated 61 percent of adults 20–74 years of age were overweight with 27 percent obese, based on preliminary data (figure 8).

The prevalence of **overweight** among children and adolescents rose from 1976–80 to 1999. In 1999 an estimated 13 percent of children 6–11 years of age and 14 percent of adolescents 12–19 years of age were overweight, based on preliminary data (figure 8).

Almost 40 percent of adults reported that they did not engage in **physical activity during leisure time** in 2000. The percent of adults who were physically inactive increased with age, and at most ages women were more likely to be inactive than men (figure 10).

Among current drinkers, 43 percent of men and 19 percent of women reported drinking **five or more alcoholic drinks in a day** on at least one day in the past year in 2000. This level of alcohol consumption was most common among young adults 18–24 years of age (table 67).

The prevalence of **illicit drug use** within the past 30 days among youths 12–17 years of age remained essentially unchanged between 1999 and 2000 at about 10 percent. The percent of youths reporting illicit drug use increased with age, ranging from 3 percent among those 12–13 years to over 16 percent among those 16–17 years in 2000 (table 64).

The number of **cocaine-related emergency department episodes** per 100,000 population for persons 35 years and over increased steadily throughout the 1990s to 68 per 100,000 in 2000. Among those 26–34 years, the age group with the highest episode rate, the 2000 rate (155 per 100,000) declined for the second year in a row. The same patient may be involved in multiple drug-related episodes (table 66).

In 2000 about one-half of **substance abuse clients in specialty treatment units** were receiving treatment for both alcoholism and drug abuse (table 86).

The presence of unacceptable levels of ground-level **ozone** is the largest source of air pollution. In 2000 approximately 42 percent of the U.S. population lived in areas designated as nonattainment areas for established health-based standards for ozone (table 52).

Morbidity

Limitation of activity due to chronic health conditions and self-assessed (or family member-assessed) health status are two summary measures of morbidity presented in this report. Additional measures of morbidity that are presented include the incidence of specific diseases, injury-related emergency department use, and suicide attempts.

Limitation of activity due to chronic health conditions occurs about twice as often among boys as girls and is significantly higher among school-age children than preschoolers. Among children 5–17 years, 9 percent of boys and 5 percent of girls had an activity limitation in 1998–2000 with the majority classified as having a limitation based on participation in special education (figure 15).

Limitations in handling personal care needs such as bathing (**activities of daily living or ADLs**) and routine needs such as shopping (**instrumental activities of daily living or IADLs**) increase sharply with age among the noninstitutionalized population. Among adults 75 years of age and over, nearly 10 percent reported ADL limitations and nearly 20 percent reported IADL limitations in 1998–2000 (figure 16 and table 58).

The relative importance of different **chronic conditions** as causes of activity limitation differs by age. Among younger adults 18–44 years the most frequently mentioned chronic conditions causing limitations were arthritis and other musculoskeletal conditions and mental illness in 1998–2000. Among adults 45 years of age and older arthritis and other musculoskeletal conditions and heart and other circulatory conditions outranked other conditions as causes of activity limitation (figure 17).

The percent of noninstitutionalized adults reporting **fair or poor health** increases substantially through middle and old age. In 2000 about 1 in 10 persons 45–54 years of age reported fair or poor health status compared with 1 in 5 persons ages 55–64 years, 1 in 4 persons ages 65–74 years, and 1 in 3 persons 75 years of age and older (table 59).

Of the more than 40,000 new **AIDS cases** in 2000, 3 out of 4 were male. New AIDS cases dropped more for men than for women in 2000. Among males 13 years of age and over, 11 percent fewer new AIDS cases were reported in 2000 than in 1999 while among females in the same age group, 4 percent fewer cases were reported (table 54).

Syphilis facilitates transmission of HIV disease. The incidence rate of primary and secondary syphilis in 2000 (2.2 cases per 100,000 population) was the lowest since national reporting began in 1941. However, the average annual rate of decline in primary and secondary syphilis slowed to 8 percent between 1998 and 2000, following average reductions of

more than 20 percent per year since the last major syphilis epidemic peaked in 1990 (table 53).

Gonorrhea causes infertility and also facilitates transmission of HIV disease. In 1998–2000 gonorrhea incidence was relatively stable at 132 cases per 100,000 population, following an average annual decline of 11 percent between 1990 and 1997 (table 53).

In 2000 the reported rate for **chlamydial infection** was 257 cases per 100,000 persons. Rates of reported chlamydial infection have been increasing annually since the late 1980s when public programs for screening and treatment of women were first established to avert pelvic inflammatory disease and related complications (table 53).

Incidence rates for **all cancers combined** declined in the 1990s for males but not for females. Between 1990 and 1998 age-adjusted cancer incidence rates declined on average more than 2 percent per year for non-Hispanic white males and Hispanic males and almost 2 percent for black males. Although there was no significant change in cancer incidence for females overall, among Hispanic females rates decreased on average 1 percent per year, and among Asian or Pacific Islander females rates increased almost 1 percent per year (table 56).

The most frequently diagnosed **cancer sites in males** are prostate, followed by lung and bronchus and colon and rectum. Cancer incidence at these sites is higher for black males than for males of other racial and ethnic groups. In 1998 age-adjusted cancer incidence rates for black males exceeded those for white males by 64 percent for prostate, 43 percent for lung and bronchus, and 11 percent for colon and rectum (table 56).

Breast cancer is the most frequently diagnosed cancer among females. Breast cancer incidence is higher for non-Hispanic white females than for females in other racial and ethnic groups. In 1998 age-adjusted breast cancer incidence rates for non-Hispanic white females exceeded those for black females by 27 percent, for Asian or Pacific Islander females by 46 percent, and for Hispanic females by 78 percent (table 56).

Injuries accounted for 37 percent of all visits to emergency departments (ED) in 1999–2000. The proportion of ED visits that were injury-related declined with age from 41 percent for children and adults under 45 years of age to 33 percent for persons 45–64 years and 26 percent for those 65 years and over. In 1999–2000 falls was the most often cited reason for injury-related ED visits among persons 45 years of age and older (tables 83 and 84).

Between 1993 and 2001 the percent of high school students who reported attempting suicide (8–9 percent) and whose **suicide attempts** required medical attention (about 3 percent) remained fairly constant. Girls were more likely than boys to consider or attempt suicide and were also more likely to make an attempt that required medical attention. However, in 1999 adolescent boys (15–19 years of age) were five times as likely to die from suicide as were adolescent girls, in part reflecting their choice of more lethal methods, such as firearms (tables 47 and 60).

Mortality Trends

Life expectancy and infant mortality are measures often used to gauge the overall health of a population. Over the past 50 years overall mortality has declined substantially among Americans of all ages.

In 2000 **life expectancy** at birth for the total population reached a record high of 76.9 years, based on preliminary data. In 1999 life expectancy was 76.7 years (table 28).

During the 20th century **life expectancy** at birth increased from 48 to 74 years for males and from 51 to 79 years for females. Life expectancy at age 65 rose from 12 to 16 years for men and from 12 to 19 years for women (figure 18).

In 2000 the **infant mortality** rate declined to a record low of 6.9 infant deaths per 1,000 live births, based on preliminary data. In 1999 the infant mortality rate was 7.1 per 1,000 (table 23).

Between 1950 and 1999 the **infant mortality rate** declined by about 75 percent. Substantial declines occurred in mortality during the first month of life (neonatal) as well as after the first month of life (postneonatal) (figure 19 and table 23).

Since 1950 **mortality among children and young adults** (ages 1–24 years) has declined by more than one-half. Overall mortality at ages 1–24 years has declined, in part, due to decreases in death rates for unintentional injuries, cancer, heart disease, and infectious diseases. Homicide and suicide rates generally increased over this period, but have declined since the mid-1990s (figures 21 and 22).

Between 1950 and 1999 **mortality among adults 25–44 years** declined by more than 40 percent overall. Death rates

for unintentional injuries, cancer, heart disease, and tuberculosis decreased substantially during this period. Suicide rates rose through 1980 and have since declined slightly. HIV disease was the leading cause of death in this age group in the mid-1990s; with decreasing HIV disease death rates, it dropped to the fifth leading cause of death in 1999 (figures 23 and 24).

Since 1950 **mortality among adults 45–64 years** has decreased by nearly 50 percent overall. During this period death rates for heart disease, stroke, and unintentional injury decreased while cancer mortality rose slowly through the 1980s and then declined. Cancer is the leading cause of death for 45–64 year olds, accounting for more than one-third of deaths in this age group in 1999 (figures 25 and 26).

During the past 50 years **mortality among elderly persons 65 years of age and over** has dropped by about one-third. During this period death rates for heart disease and stroke have declined sharply while the death rate for cancer rose until 1995 and has since decreased slightly (figure 27).

Disparities in Mortality

Despite overall declines in mortality, racial and ethnic disparities as well as gender disparities in mortality persist. The gap in life expectancy between the sexes and between the black and white populations has been narrowing.

Infant mortality rates have declined for all racial and ethnic groups, but large disparities remain. In 1997–99 the infant mortality rate was highest for infants of non-Hispanic black mothers (13.9 deaths per 1,000 live births) and lowest for infants of Chinese mothers (3.3 per 1,000 live births) (figure 20 and table 20).

Infant mortality increases as mother's level of education decreases. In 1999 the mortality rate for infants of mothers with less than 12 years of education was 57 percent higher than for infants of mothers with 13 or more years of education. This disparity was more marked among non-Hispanic white infants, for whom mortality among infants of mothers with less than a high school education was more than twice that for infants of mothers with more than a high school education (table 21).

Life expectancy at birth increased more for **males** than for **females** between 1990 and 2000, reducing the difference in life expectancy between the sexes. The difference in life expectancy between males and females narrowed from 7 years in 1990 to 5.5 years in 1999 and 5.4 years in 2000 (preliminary data) (table 28).

During the 1990s **mortality from lung cancer** declined for **men** and increased for **women**. Although these trends reduced the sex differential for this cause of death, the age-adjusted death rate for lung cancer was still 89 percent higher for men than for women in 1999 and 84 percent higher in 2000 (preliminary data) (table 40).

During the 1990s mortality from **chronic lower respiratory diseases** remained relatively stable for **men** while it increased for **women**. These trends reduced the gap between the sexes for this cause of death. In 1990 the age-adjusted death rate for males was more than 100 percent higher than for females. In 1999 the difference between the rates had been reduced to 52 percent, and in 2000, to 45 percent (preliminary data) (table 42).

Between 1990 and 2000 **life expectancy at birth** increased more for the **black** than for the **white population**, thereby narrowing the gap in life expectancy between these two racial groups. In 1990 life expectancy at birth was 7 years longer for the white than for the black population. By 1999 the difference had narrowed to 5.9 years and by 2000, to 5.6 years (preliminary data) (table 28).

Overall mortality was one-third higher for **black Americans** than for white Americans in 1999, compared with 37 percent higher in 1990. In 1999 age-adjusted death rates for the black population exceeded those for the white population by 38 percent for **stroke**, 28 percent for **heart disease**, 27 percent for **cancer**, and more than 700 percent for **HIV disease** (table 30).

The **5-year survival rate** for black females diagnosed in 1989–97 with breast cancer was 15 percentage points lower than for white females. In 1999 **breast cancer mortality** was 35 percent higher for black females than for white females, compared with 15 percent higher in 1990 (tables 41 and 57).

Homicide rates among young black males 15–24 years of age and among **young Hispanic males** were nearly 50 percent lower in 1999 than in the early 1990s when homicide rates peaked for these groups. In spite of these downward trends, homicide was still the leading cause of death for young black males and the second leading cause for young Hispanic males in 1999, and homicide rates for young black and Hispanic males remained substantially higher than for young non-Hispanic white males (table 46).

Since 1995 death rates for **HIV disease** declined sharply **for black males and Hispanic males** 25–44 years of age. In spite of these declines, HIV disease was still the leading cause of death for black males 25–44 years of age and the third leading cause for Hispanic males 25–44 years of age in 1999, and HIV death rates remained much higher for black and Hispanic males than for non-Hispanic white males in this age group (table 43).

In 1999 the death rate for **motor vehicle-related injuries for young American Indian males** 15–24 years of age was almost twice the rate for young white males, and the **suicide** rate for young American Indian males was double the rate for young white males. Death rates for the American Indian population are known to be underestimated (tables 45 and 47).

Between 1990 and 1999 death rates for **stroke** declined for white males 45–54 and 55–64 years of age but not for **Asian American males** in these age groups. In 1999 death rates for stroke were 31–40 percent higher for middle-aged Asian American males than for middle-aged white males. Death rates for the Asian American population are also known to be underestimated (table 38).

Occupational Health

Improvements in workplace safety constitute a major public health achievement in the 20th century. Despite important accomplishments, preventable injuries and deaths continue to occur.

In 1999–2000 the **occupational injuries with lost workdays** rate, 2.8 per 100 full-time equivalents (FTEs) in the private sector, was at its lowest level in 2 decades. The industries reporting the highest injury rates in 2000 were transportation, communication, and public utilities (4.1 per 100 FTEs), and construction and manufacturing (both reporting 4.0) (table 51).

Between 1992 and 2000 the **occupational injury death rate** decreased 17 percent to 4.3 deaths per 100,000 employed workers. Mining, the industry with the highest death rate in 2000 (30 per 100,000), accounted for less than 3 percent of all occupational injury deaths. Construction, with a death rate of 13 per 100,000, accounted for 20 percent of all occupational injury deaths in 2000 (table 50).

A total of 2,739 **pneumoconiosis deaths**, for which pneumoconiosis was the underlying or nonunderlying cause of death, occurred in 1999, compared with 4,151 deaths in 1980. Pneumoconiosis deaths are largely associated with occupational exposures and can be prevented through effective control of worker exposure to occupational dusts (table 49).

Health Care Utilization and Resources

Preventive Health Care

Use of preventive health services helps reduce morbidity and mortality from disease. Use of several different types of preventive services has been increasing. However, disparities in use of preventive health care by race and ethnicity and by family income remain.

Between 1990 and 2000 the percent of mothers receiving **prenatal care** in the first trimester of pregnancy increased from 76 to 83 percent. Although increases occurred for all racial and ethnic groups, in 2000 the percent of mothers with early prenatal care still varied substantially, from 69 percent for American Indian mothers to 91–92 percent for Japanese and Cuban mothers (figures 11 and 12 and table 6).

In 2000, 76 percent of children 19–35 months of age received the combined **vaccination** series of 4 doses of DTP (diphtheria-tetanus-pertussis/acellular pertussis) vaccine, 3 doses of polio vaccine, 1 dose of measles-containing vaccine, and 3 doses of Hib (Haemophilus influenzae type b) vaccine. Children living below the poverty threshold were less likely to have received the combined vaccination series than were children living at or above poverty (71 percent compared with 78 percent) (table 73).

Annual **influenza vaccination** can prevent complications of influenza illness and one dose of **pneumococcal vaccine** can reduce the risk of invasive pneumococcal disease. Between 1989 and 2000 the percent of elderly adults reporting influenza vaccination within the past year doubled to 65 percent and the percent ever receiving a pneumococcal vaccine increased from 14 to 53 percent (figure 13).

Between 1987 and 2000 the percent of women 40 years of age and over who reported a **mammogram** within the past 2 years more than doubled from 29 to 70 percent. Women with less than a high school education are much less likely than those with some college education to report a recent mammogram (58 percent compared with 76 percent in 2000) (table 82).

Uninsurance and Access to Health Care

Access to health care is important for preventive care and for prompt treatment of illness and injuries. Indicators of access to health care services include having a usual source of health care, having a recent health care contact, and use of the emergency department. Health insurance coverage is a major determinant of access to health care.

The percent of the nonelderly population with no health insurance coverage (either public or private) fluctuated around 16–17 percent between 1994 and 2000. Among the nonelderly population, poor and near poor persons are much more likely than others to be **uninsured** (figures 5 and 6 and table 129).

The likelihood of being **uninsured** varies substantially among the States. In 2000 the percent of the nonelderly population with no health care coverage varied from less than 10 percent in New Hampshire, Rhode Island, Pennsylvania, and Wisconsin to more than 20 percent in Florida, Louisiana, Oklahoma, Texas, New Mexico, Montana, and Alaska (table 147).

Twelve percent of **children** under 18 years of age had **no health insurance coverage** in 2000. Children with low family income were more likely than higher income children to lack coverage (26 percent among those with family income 1–1.5 times the poverty level compared with 6 percent among those with income at least twice the poverty level) (table 129).

Seven percent of **children** under 18 years of age had **no usual source of health care** in 1999–2000. Uninsured children were substantially more likely to be without a usual source of care than insured children (29 percent compared with 4 percent) (table 76).

Thirteen percent of **children** under 18 years of age had **no health care visit** to a doctor or clinic within the past 12 months in 1999–2000. Uninsured children were nearly three times as likely to be without a recent visit as insured children (30 percent compared with 11 percent) (table 75).

One in 5 **children** under 18 years of age had an **emergency department (ED) visit** within the past 12 months in 2000. Children with Medicaid coverage were more likely than those with private coverage to have had an ED visit within the past 12 months (29 percent compared with 18 percent) (table 77).

Among **adults 18–64 years of age**, the uninsured were more than 4 times as likely as those with health insurance coverage to have **no usual source of health care** in 1999–2000 (47 percent compared with 11 percent). Men in this age group were twice as likely as women to be without a usual source of health care (24 percent compared with 12 percent) (percents are age adjusted) (table 78).

Emergency department (ED) use among nonelderly adults 18–64 years of age is greater among those covered by Medicaid than among the privately insured or uninsured. Forty-two percent of nonelderly adults with Medicaid reported at least one ED visit in 2000 compared with 18 percent of the privately insured and 20 percent of the uninsured (percents are age adjusted) (table 79).

Use of dental care is greater among persons with higher family incomes. In 2000 almost three-quarters of persons with higher family income (at least twice the poverty level) had a **dental visit** in the past year compared with about one-half of persons with family income less than twice the poverty level (percents are age adjusted) (table 80).

Outpatient Care

Major changes continue to occur in the delivery of health care in the United States, driven in large part by the need to rein in rising costs. Use of inpatient services has decreased while use of outpatient services, such as outpatient surgery, home health care, and hospice care, has increased.

In 2000, 63 percent of all **surgical operations** in community hospitals were performed on outpatients, up from 51 percent in 1990 and 16 percent in 1980 (table 96).

Between 1996 and 2000 use of **home health care** by persons 65 years of age and over declined from 547 to 276 per 10,000 population, after increasing steadily between 1992 and 1996. The recent decline was a result of the Balanced Budget Act of 1997, which imposed stricter limits on the use of home health services funded by Medicare and interim limits on Medicare payments to home health agencies from October 1997 until a prospective payment system was implemented for Medicare home health agencies in October 2000 (data are age adjusted) (table 88).

Use of **hospice care** by persons 65 years of age and over increased by 83 percent to 25 patients per 10,000 population during the period 1994–2000. Among the elderly use of hospice services was slightly higher for males than for females (27 compared with 23 patients per 10,000 in 2000). Cancer was the most common diagnosis among hospice patients (data are age adjusted) (table 89).

Inpatient Care and Resources

Use of hospital inpatient services has declined, as has the number of beds in community hospitals. Nursing home use has also declined.

Between 1985 and 2000 the **hospital discharge rate** declined 24 percent, from 151 to 115 discharges per 1,000 population, while **average length of stay** declined 1.7 days, from 6.6 to 4.9 days (data are age adjusted) (table 91).

Use of hospital inpatient care is greater among the poor than among those with higher family income (at least twice the poverty level). In 2000 among nonelderly persons, the hospital discharge rate for the poor was more than twice the rate for those with higher family income (172 and 82 per 1,000 population). Average length of stay was 1.3 days longer for poor than for higher income persons (4.7 and 3.4 days) (data are age adjusted) (table 90).

Between 1990 and 2000 the number of **community hospital beds** declined from about 927,000 to about 824,000. Community hospital occupancy, estimated at 64 percent in 2000, has been relatively stable since the mid-1990s, after declining from 67 percent in 1990 and 76 percent in 1980 (table 107).

In 1999 there were almost 1.5 million elderly **nursing home residents** 65 years of age and over. More than one-half of the elderly residents were 85 years of age and over and almost three-fourths were female. Between the mid-1970s and 1999, nursing home utilization rates increased for the black population and decreased for the white population (table 97).

In 2000 there were 1.8 million **nursing home beds** in facilities certified for use by Medicare and Medicaid beneficiaries. Between 1995 and 2000 nursing home bed occupancy in those facilities was relatively stable, estimated at 82 percent in 2000 (table 111).

Health Care Expenditures

National Health Expenditures

After 25 years of double-digit annual growth in national health expenditures, the rate of growth slowed during the 1990s. At the end of the decade the rate of growth started edging up again. In 2000 health expenditures increased by almost 7 percent. The United States continues to spend more on health than any other industrialized country.

In 2000 **national health care expenditures** in the United States totaled $1.3 trillion, increasing 6.9 percent from the previous year compared with a 5.7 percent increase in 1999. In the mid-1990s annual growth had slowed somewhat, following an average annual growth rate of 11 percent during the 1980s (table 113).

The rate of increase in the medical care component of the **Consumer Price Index** (CPI) rose to 4.6 percent in 2001 from 3.4 percent per year during 1995–2000. During the last two years, the CPI for hospital services showed the greatest price increases (6.6 percent in 2001 and 6.0 percent in 2000) compared with other components of medical care (table 114).

In 2000 **health expenditures as a percent of the gross domestic product (GDP)** increased to 13.2 percent, up from 13.1 percent the previous three years (table 113).

The United States spends a larger **share of the GDP on health** than any other major industrialized country. In 1998 the United States devoted 13.1 percent of the GDP to health compared with 10.3–10.4 percent each in Switzerland and Germany and 9.3–9.4 percent in Canada, France, and Norway, countries with the next highest shares (table 112).

Expenditures by Type of Care and Source of Funds

During the last few years expenditures for prescription drugs have grown at a faster rate than any other type of health expenditure. The sources of funds for medical care differ substantially according to the type of medical care being provided.

Expenditures for hospital care accounted for 32 percent of all national health expenditures in 2000. Physician services accounted for 22 percent of the total in 2000, prescription drugs for 9 percent, and nursing home care for 7 percent (table 116).

From 1995–2000 the average annual rate of increase for **prescription drug expenditures** (15 percent) was higher than for any other type of health expenditure. During the first half of the decade expenditures for home health care increased more rapidly (19 percent per year) than other types of expenditures (table 116).

In 2000 **prescription drug expenditures** increased 17 percent and prescription drugs posted a 4.4 percent rate of price increase in the Consumer Price Index. In 2001 the price of prescription drugs increased 5.4 percent (tables 114 and 116).

In 2000, 46 percent of **prescription drug expenditures** were paid by private health insurance (up from one-quarter at the beginning of the decade), 32 percent by out-of-pocket payments (down from 59 percent in 1990), and 17 percent by Medicaid. Although Medicare is the Federal program that funds health care for the elderly, and the elderly are the highest per capita consumers of prescription drugs, only 2 percent of prescription drug expenses were paid by Medicare in 2000 (table 117).

In 1998, 88 percent of elderly persons in the civilian noninstitutionalized population had a **prescribed medicine expense**. The average annual out-of-pocket prescribed medicine expense per elderly person with expense was $531 (table 118).

In 1998, 95 percent of **elderly persons** in the civilian noninstitutionalized population reported **medical expenses** averaging $6,300 per person with expense. Fifteen percent of expenses were paid out-of-pocket, 14 percent by private insurance, and 68 percent by public programs (mainly Medicare and Medicaid) (table 118).

In 2000, 33 percent of **personal health care expenditures** were paid by the Federal Government and 11 percent by State and local government; private health insurance paid 35 percent and consumers paid 17 percent out-of-pocket (table 117).

In 2000 the major **sources of funds** for hospital care were Medicare (31 percent) and private health insurance (33 percent). Physician services were also primarily funded by private health insurance (48 percent) and Medicare (21 percent). In contrast, nursing home care was financed primarily by Medicaid (48 percent) and out-of-pocket payments (27 percent) (table 117).

In 1999 the average monthly charge per **nursing home** resident was $3,891. Residents for whom the source of payment was private insurance, family support, or their own income paid close to the average charge, compared with an average monthly charge of $5,800 when Medicare was the payor and $3,500 when Medicaid was the source of payment (table 123).

Publicly Funded Health Programs

The two major publicly funded health programs are Medicare and Medicaid. Medicare is funded by the Federal Government and reimburses elderly and disabled persons for their health care. Medicaid is funded jointly by the Federal and State Governments to provide health care for the poor. Medicaid benefits and eligibility vary by State.

In 2000 the **Medicare** program had 40 million enrollees and expenditures of $222 billion (table 134).

In 2000 **hospital insurance** (HI) accounted for 59 percent of Medicare expenditures. Expenditures for home health agency care decreased to 3 percent of HI expenditures in 2000, down from 14 percent in 1995 (table 134).

In 2000 **supplementary medical insurance** (SMI) accounted for 41 percent of Medicare expenditures. One-fifth of SMI expenditures in 2000 were payments to managed care organizations and the remainder were payments for fee-for-service utilization (table 134).

Of the 29 million **Medicare enrollees in the fee-for-service program** in 1999, 13 percent were 85 years of age and over and 13 percent were under 65 years of age. Among elderly fee-for-service Medicare enrollees, payments increased with age from an average of $4,000 per year per enrollee for those aged 65–74 years to $7,400 for those 85 years and over. Average payments per fee-for-service enrollee declined in 1998 and 1999 (table 135).

In 1998, 82 percent of **Medicare beneficiaries** were non-Hispanic white, 9 percent were non-Hispanic black, and 7 percent were Hispanic. Some 21–24 percent of Hispanic and non-Hispanic black beneficiaries were persons under 65 entitled to **Medicare through disability** compared with 11 percent of non-Hispanic white beneficiaries (table 136).

In 1999 **Medicare payments per enrollee** varied by State, ranging from less than $4,000 in Hawaii, Montana, Utah, North Dakota, South Dakota, Idaho, and Iowa to more than $6,200 in New York, New Jersey, Maryland, the District of Columbia, and Louisiana (table 144).

In 1998 **Medicaid** vendor payments totaled $142 billion for 41 million recipients (table 137).

In 1998 children under the age of 21 years accounted for 47 percent of **Medicaid recipients** but only 16 percent of expenditures. Aged, blind, and disabled persons accounted for

26 percent of recipients and 71 percent of expenditures (table 137).

In 1998, 22 percent of **Medicaid payments** went to nursing facilities, 15 percent to inpatient general hospitals, 14 percent to prepaid health care, and 10 percent to prescribed drugs (table 138).

In 1999 spending on health care by the **Department of Veterans Affairs** was $17.9 billion. Fifty-four percent of inpatients and 40 percent of outpatients were low-income veterans without a service-connected disability (table 139).

Private Health Insurance

More than 70 percent of the population under 65 years of age has private health insurance, most of which is obtained through the workplace. The share of employees' total compensation devoted to health insurance had been declining in recent years, but increased in 2000 and again in 2001 due to increases in health insurance premiums.

Between 1995 and 2000 the age-adjusted proportion of the population under 65 years of age with **private health insurance** fluctuated between 71 and 73 percent after declining from 77 percent in 1984. More than 90 percent of private coverage was obtained through the workplace (a current or former employer or union) in 2000 (figure 5 and table 127).

In 2001 **private employers' health insurance costs** per employee-hour worked increased to $1.28 up from $1.09 in 2000. Among private employers the share of total compensation devoted to health insurance was 6.2 percent in 2001, up from 5.5 percent in 2000 (table 120).

Health Maintenance Organizations (HMOs)

An HMO is a prepaid health plan delivering comprehensive care to members through designated providers. Almost 30 percent of all persons in the United States are enrolled in HMOs.

Enrollment in HMOs totaled 80 million persons or 28 percent of the U.S. population in 2001. HMO enrollment varied from 21–22 percent in the Midwest and South to 35 percent in the Northeast and 41 percent in the West. HMO enrollment increased steadily through 1999 but declined by nearly 2 million between 1999 and 2001. The number of HMO plans decreased by 16 percent, to 541 plans during these 2 years (table 132).

In 2001 the percent of the population enrolled in **HMOs** varied among the **States**, from 0 in Alaska to 44 percent in Massachusetts and 53 percent in California. Other States with 38 percent or more of the population enrolled in HMOs in 2001 included New Hampshire, Connecticut, and Maryland (table 146).

In 2000, 38 percent of children had health insurance coverage through a **private, Medicaid, or Medicare HMO** compared with about one-third of adults 18–64 years of age and one-quarter of the elderly. Nine percent of children (12 percent of those under 6 years of age) were in a Medicaid HMO compared with less than 3 percent of nonelderly adults. Fifteen percent of the elderly were in a Medicare HMO and 13 percent in a private HMO (table 131).

The proportion of the elderly population enrolled in **Medicare HMOs** in 2000 ranged from 8 percent in the Midwest to 31 percent in the West (table 131).

State Health Expenditures

Total personal health care per capita expenditures and its components vary substantially among the States.

Personal health care per capita expenditures averaged $3,800 in 1998, but varied among the States from $2,700 in Utah to $4,800 in Massachusetts. Higher expenditures were clustered in the New England and Mideastern States with lower per capita expenditures in the Rocky Mountain, Southwestern, and Far West States (table 140).

The components of personal health care expenditures also vary significantly by State. **Hospital care** per capita expenditures in 1998 ranged from $1,030 in Utah to $1,800 in New York. **Physician** and other professional services per capita expenditures varied from $760 in Utah to $1,350 in Minnesota. Per capita expenditures for **nursing home care** ranged from $90 in Alaska to $860 in Connecticut (table 140).

Twenty-one percent of all personal health care expenditures were paid by **Medicare** in 1998, up from 17 percent in 1991. The Medicare share of State health expenditures in 1998 varied from 8 percent in Alaska to 25–27 percent in Mississippi, Louisiana, and Pennsylvania and 28 percent in Florida (table 141).

The share of personal health care expenditures paid by **Medicaid** increased from 13 percent in 1991 to 16 percent in 1995 through 1998. The Medicaid share of personal health care expenditures was less than 10 percent in Nevada and Virginia, and reached 21 percent in the District of Columbia, Rhode Island, and Maine, and 31 percent in New York (table 142).